1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05189

CERTIFICATE OF DEATH

05187

1. PLACE OF DEATH
a. COUNTY: Harford. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
d. STREET ADDRESS: Rt #1, Box 302
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Walter Middle: William Last: Ash.

4. DATE OF DEATH: Month: 4 Day: 26 Year: 1967

5. SEX: Male

6. COLOR OR RACE: Negro.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 10, 1882

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Lewis Ash.

14. MOTHER'S MAIDEN NAME: Mary Presbury.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 220-54-7000T

17. INFORMANT: Mrs. Carrie Ash, Havre de Grace Md. Address: Rt #1 Box 302

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH: 3 days
4221
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): A.S.C.V.D. — ? years
DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus + Malnutrition.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (i) (this hospital) attended the deceased from 4-14, 1967, to 4-26, 1967, that (I) (we) last saw the deceased alive on 4-26, 1967, and that death occurred at 6:45 PM, from the causes and on the date stated above.

22a. SIGNATURE: Edward C. Loo, M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/26/67

22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.

22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 30, 1967

23c. NAME OF CEMETERY OR CREMATORY: St. James A.M.E. Cemetery

23d. LOCATION (City, town or county) (State): Grenly Hill Harford Co. Md

24. FUNERAL DIRECTOR: Celia L. Bullock ADDRESS: Havre de Grace Md.

25a. REC'D BY REGISTRAR DATE: MAY 5 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05190

CERTIFICATE OF DEATH

05188

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Harford — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
   c. LENGTH OF STAY IN 1b: 2 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Harford
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air - 12.1 Rural
   d. STREET ADDRESS: Alibone Rd. (RFD #1, Box #224)
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Fielder — Last: Black

4. DATE OF DEATH: Month: April — Day: 29 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 5, 1890

9. AGE (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (County & State, or foreign country): Grayson Co., Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel Black

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 218-14-7122 A

17. INFORMANT (Son) 838-3269: Mr. Harry L. Black — Address: RFD #1, Box #224, Bel Air, Maryland 21014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive and Arteriosclerotic
DUE TO (c): Cardiovascular Disease ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 27, 1967, to April 29, 1967, that (I) (we) last saw the deceased alive on April 29 1967, and that death occurred at 1:40 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Edward C. Loo, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: April 29th 67

22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.

22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 1, 1967

23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens

23d. LOCATION (City, town or county) (State): Bel Air, Harford Co., Maryland 21014

24. FUNERAL DIRECTOR: Joseph William Foster — ADDRESS: W. Broadway & Williams St. Bel Air, Maryland 21014

25a. REC'D BY REGISTRAR DATE: MAY 2 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

Joseph William Foster

VR A15 (4)
15M 4-64

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05191

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05189

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: N. Y.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New Rochelle
d. STREET ADDRESS: 1 Mt Joy Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Lee Middle Evelyn C. Last Brown
4. DATE OF DEATH: Month April Day 10 Year 19 67
5. SEX: F
6. COLOR OR RACE: C
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-16-41
9. AGE (In years last birthday): 25 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: Private family
11. BIRTHPLACE (State or foreign country): Robeson County, N.C.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Willie Christian
14. MOTHER'S MAIDEN NAME: Lucille Small
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Mr. Willie Christian, Laurinburg, N.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Injuries — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b)
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.): Auto Accident
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 4-10 67
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route 7
20f. (City or town) Harford (County) (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald E Palmer M.D. M.D.
EXAMINER'S NAME (Type): Gerald E Palmer M.D.
CHIEF MEDICAL EXAMINER ☐ Bel Air Md.
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED: 4-10-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: April 16, 1967
23c. NAME OF CEMETERY OR CREMATORY: Pine Grove Cemetery
23d. LOCATION (City or Town) (County) (State): Maxton N.C.

24. FUNERAL DIRECTOR: Elmer F Bullock — ADDRESS: 556 Lewis Street Havre de Grace Md
25a. REC'D BY REGISTRAR DATE: APR 13 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05192

CERTIFICATE OF DEATH

05190

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYland — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
d. STREET ADDRESS: Rt. 155 STAR Route
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: HERMAN — Last: Clow

4. DATE OF DEATH: Month: April — Day: 26 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAR. 6 1909

9. AGE (In years last birthday): 58 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SUPERVISOR OF PUBLIC PERSONNEL

10b. KIND OF BUSINESS OR INDUSTRY: RETIRED

11. BIRTHPLACE (County & State, or foreign country): PA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES. H. CLOW SR.

14. MOTHER'S MAIDEN NAME: EMILY VIOLA SHRIVER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): —
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 214-32-2042

17. INFORMANT: Mrs. DOLLY R. CLOW, HAVRE DE GRACE MD. — Address: STAR Route

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 6 hr
DUE TO (b): Arteriosclerotic Heart Dis. — 8 yr.
DUE TO (c): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebro Arteriosclerosis & Tachycardia — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

3

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11-12-62, 19__, to 4-26-1967, that (I) (we) last saw the deceased alive on April 26, 1967, and that death occurred at 3:45 M, from the causes and on the date stated above.

22a. SIGNATURE: Peter P. Rodman, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 4-27-67

22c. PHYSICIAN'S NAME (Type): Peter P. Rodman, M.D. — 22d. ADDRESS: Aberdeen, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: APRIL 29 1967 — 23c. NAME OF CEMETERY OR CREMATORY: SUDERSVILLE CEM. — 23d. LOCATION (City, town or county) (State): SUDERSVILLE MD

24. FUNERAL DIRECTOR: R. Madison Mitchell — ADDRESS: Havre de Grace, Md. — 25a. REC'D BY REGISTRAR DATE: MAY 1 1967 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05193 05191

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH: a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air
c. LENGTH OF STAY IN 1b 27 MONTHS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.F.D. 1

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air 21014
d. STREET ADDRESS 309 S. Main St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Olive Middle M. Last Cullum
4. DATE OF DEATH Month April Day 5 Year 1967
5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Mar. 16, 1910
9. AGE (In years last birthday) 57 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) STREET, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Archer W. Cullum
14. MOTHER'S MAIDEN NAME Lavinia Bull

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 215-32-2185
17. INFORMANT Address Mrs. Vernon Smith, Street, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma Breast with Metastases — INTERVAL BETWEEN ONSET AND DEATH
170X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐
ACTUAL SIGNATURE Gerald C Palmer M.D.
EXAMINER'S NAME (Type) Gerald C Palmer MD
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county) Bel Air, Md.
22. DATE SIGNED 4-5-67

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF APR. 8, 1967
23c. NAME OF CEMETERY OR CREMATORY Dublin Southern
23d. LOCATION (City or Town) (County) (State) Dublin, Harford, Md.
24. FUNERAL DIRECTOR ADDRESS John H. Harkins, Delta, Pa.
25a. REC'D BY REGISTRAR DATE APR 10 1967
25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deloy is necessary, pleose execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Exominer's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05194 05192

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Havre-de-Grace
c. LENGTH OF STAY IN 1b: 33 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md — b. COUNTY: Cecil
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Perryville
d. STREET ADDRESS: Susquehanna Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Addie — Middle: Virginia — Lost: Cunningham

4. DATE OF DEATH: Month: 4 — Day: 9 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Mar. 4, 1881

9. AGE (In years last birthday): 86 yrs.

IF UNDER 1 YEAR: Months: ____ Days: ____
IF UNDER 24 HRS.: Hours: ____ Min.: ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ---------

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Richardson

14. MOTHER'S MAIDEN NAME: Martha Dye

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): -----

16. SOCIAL SECURITY NO.: Unkown

17. INFORMANT: Mrs. Helen C. Gillespie — Address: Perryville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction
DUE TO (b): A.S.C.V.D
DUE TO (c): old age
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.

INTERVAL BETWEEN ONSET AND DEATH: 3 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospitol) attended the deceased from 4-1, 1967 to 4-9, 1967; that (I) (we) last saw the deceased alive on 4-9 1967, and that death occurred at 9:21 M, from couses and on the date stated obave.

22a. SIGNATURE: John D. Yun — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/10/67

22c. PHYSICIAN'S NAME (Type): John D. Yun

22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 12, 1967

23c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery

23d. LOCATION (City or Town) (County) (State): Port Deposit, Maryland.

24. FUNERAL DIRECTOR: Lee A. Patterson & Son — ADDRESS: Perryville, Md.

25a. REC'D BY REGISTRAR DATE: APR 17 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05195 05193

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Harford — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: New York — b. COUNTY: Queens
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Astoria Long Island 69
   d. STREET ADDRESS: 33-03 24th Ave
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marie — Middle: Elizabeth — Last: Dolan

4. DATE OF DEATH: Month: April — Day: 20 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 1, 1903

9. AGE (In years last birthday): 63 yrs.
   IF UNDER 1 YEAR — Months: — Days:
   IF UNDER 24 HRS. — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Billing Dept. Clerk

10b. KIND OF BUSINESS OR INDUSTRY: General Motors

11. BIRTHPLACE (County & State, or foreign country): New York City, N.Y.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Berrill (D)

14. MOTHER'S MAIDEN NAME: Elizabeth Flynn (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
   (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 050-22-4367

17. INFORMANT — Address: James Dolan same as 2 C & D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bleeding Esophageal Varices — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO (b): Cirhosis of the Liver - Portal — 7

DUE TO (c): Hypertension — 3 days

581.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 18 April, 1967, to 20 April, 1967, that (I) (we) last saw the deceased alive on APR 20 1967, and that death occurred at 8:35 M, from the causes and on the date stated above.

22a. SIGNATURE: L. H. Sadowsky M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/20/67

22c. PHYSICIAN'S NAME (Type): W.H. SADOWSKY

22d. ADDRESS: 504 Lewis Ave. Havre de Grace

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 21 Apr. 67

23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

23d. LOCATION (City, town or county) (State): Long Island City, N.Y.

24. FUNERAL DIRECTOR: Walter Macumber Sr.

ADDRESS: Tarring Funeral Home Aberdeen, Md.

25a. REC'D BY REGISTRAR DATE: APR 24 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
15M 4-64

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05196 **CERTIFICATE OF DEATH** 05194

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: D.O.A
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Street
d. STREET ADDRESS: RD 2 Box 330
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ERNEST Middle LESLIE Last EPPERLEY
4. DATE OF DEATH: Month APRIL Day 18 Year 1967
5. SEX: Male
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 26, 1910
9. AGE (In years last birthday): 56 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck driver
10b. KIND OF BUSINESS OR INDUSTRY: Beverage
11. BIRTHPLACE (County & State, or foreign country): Pilot, Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Posey Everett Epperley
14. MOTHER'S MAIDEN NAME: Arinda Claradel Hall
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): ---
16. SOCIAL SECURITY NO.: 218-18-5214
17. INFORMANT: Clara M. Epperley — Address: RD 2 Box 330 Street, Md. 21154

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary thrombosis, recurrent — INTERVAL BETWEEN ONSET AND DEATH: 2 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Cardiovascular — 2-3 years
DUE TO (c): Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 2nd, 1967, to April 18, 1967, that (I) (we) last saw the deceased alive on April 18th, 1967, and that death occurred at 10:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Edward C. Loo, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/18/67
22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.
22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/21/1967
23c. NAME OF CEMETERY OR CREMATORY: Nazarene
23d. LOCATION (City, town or county) (State): Bel Air, Maryland

24. FUNERAL DIRECTOR — ADDRESS: Charles E. Kurtz Jarrettsville, Md.
25a. REC'D BY REGISTRAR DATE: APR 20 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

21084

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05197

CERTIFICATE OF DEATH

05195

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH** — a. COUNTY: Harford. MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
   c. LENGTH OF STAY IN 1b: 2 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Harford Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission) — a. STATE: Md. b. COUNTY: Harford
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace 12-1
   d. STREET ADDRESS: 351 Wilson St
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Rathe ~~RUTH~~ Middle: Marie Last: Forwood

4. **DATE OF DEATH**: Month: 4 Day: 29 Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/2/1911

9. AGE (In years lost birthday): 55 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): N.Y.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Peter Paul Cusick.

14. MOTHER'S MAIDEN NAME: Mary Neary.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: unk.

17. **INFORMANT**: Frank Forwood Address: 341 Morgan drive Aberdeen, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): Hypetensive and Arteriosclerotic
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Cardiovascular Disease — 7 years.
I43X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-27, 1967, to 4-29, 1967, that (I) (we) last saw the deceased alive on 4-29 1967 and that death occurred at 8:10 P M, from causes and on the date stated above.

22a. SIGNATURE: Edward C. Loo M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/30/67

22c. PHYSICIAN'S NAME (Type): Edward C. Loo M.D.

22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 5/3/67

23c. NAME OF CEMETERY OR CREMATORY: Methodist Cem.

23d. LOCATION (City or Town) (County) (State): Forest Hill Md.

24. FUNERAL DIRECTOR: Runnette Son, Inc. ADDRESS: Havre de Grace, Md

25a. REC'D BY REGISTRAR DATE: MAY 3 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05198

CERTIFICATE OF DEATH

05196

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 7 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FOREST HILL
d. STREET ADDRESS: Chestnut Hill Rd
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: MORRIS — Middle: O. — Last: FORWOOD
4. DATE OF DEATH: Month: APRIL — Day: 3 — Year: 1967
5. SEX: MALE
6. COLOR OR RACE: W
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: AUG. 13, 1880
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: DAIRY
11. BIRTHPLACE (County & State, or foreign country): FOREST HILL, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: PARKER L. FORWOOD
14. MOTHER'S MAIDEN NAME: JULIA SMITHSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: MARVYN E. FORWOOD, DELTA, PA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO (b): Arteriosclerotic Cardiovascular Disease — 2-3 years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 28, 1967, to APRIL 3, 1967 that (I) (we) last saw the deceased alive on APRIL 3 1967, and that death occurred at 10:04 A M, from causes and on the date stated above.

22a. SIGNATURE: Edward C. Loo M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 4/3/67
22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.
22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: APR. 5, 1967
23c. NAME OF CEMETERY OR CREMATORY: DEER CREEK METHODIST
23d. LOCATION (City or Town) (County) (State): CHESTNUT HILL, HARFORD, MD.

24. FUNERAL DIRECTOR — ADDRESS: John H. Harkins, DELTA, PA.
25a. REC'D BY REGISTRAR — DATE: APR 6 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05193 05197

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 3 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Brevin Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside carporate limits, write RURAL and give neorest town): Perryville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Naomi — Middle: K. — Last: Fouche
4. DATE OF DEATH: Month: April — Day: 29, — Year: 19 67
5. SEX: Female
6. COLOR OR RACE: Cau.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 31, 1897
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: ------
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: Thomas Kelly
14. MOTHER'S MAIDEN NAME: Clara McMullen
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 219-05-7793
17. INFORMANT (Address): Miss Ethel Taylor, Perryville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Sclerosis — 334X — INTERVAL BETWEEN ONSET AND DEATH: 2 mos —
DUE TO (b): Arteriosclerosis — 5 yrs —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes,
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 20, 1964, to April 27, 1967, that (I) (we) last saw the deceased alive on April 28, 1967, and that death occurred at 11:20 M, from causes and on the date stoted above.

22a. SIGNATURE: Clarence I. Benson M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/29/67
22c. PHYSICIAN'S NAME (Type): Clarence I. Benson
22d. ADDRESS: Port Deposit, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 2, 1967
23c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery
23d. LOCATION (City or Town) (County) (State): Port Deposit, Cecil Md.
24. FUNERAL DIRECTOR: Lee A. Patterson & Son
ADDRESS: Perryville, Md.
25a. REC'D BY REGISTRAR DATE: MAY 3 1967
25b. REGISTRAR'S SIGNATURE: Charles Fuge

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05200 05198

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 623 N. Stokes St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alonza — Middle: Byer — Last: Frederick

4. DATE OF DEATH: Month: April — Day: 2 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/18/1897

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Municipal Utilities

11. BIRTHPLACE (County & State, or foreign country): Harford Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John N. Frederick (dec)

14. MOTHER'S MAIDEN NAME: Maude M. Walker (dec)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT: Wilbur Frederick — Address: 623 N. Stokes St. Havre de Grace Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Interseptal Myocardial infarction; paroxysmal
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic Cardiovascular Disease — 2-3 years
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cirrhosis of the liver

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 1st, 1967, to April 2, 1967 that (I) (we) last saw the deceased alive on April 2, 1967, and that death occurred at 11 P M, from causes and on the date stated above.

22a. SIGNATURE: Edward Lee — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/3/67

22c. PHYSICIAN'S NAME (Type): Edward C. Lee, M.D.

22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 4/6/67

23c. NAME OF CEMETERY OR CREMATORY: Angel Hill

23d. LOCATION (City or Town) (County) (State): Havre de Grace Md

24. FUNERAL DIRECTOR: Pennington Bros. — ADDRESS: Havre de Grace, Md

25a. REC'D BY REGISTRAR DATE: APR 10 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05207

CERTIFICATE OF DEATH

05199

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): Aberdeen
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): 419 Baltimore Street

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): Aberdeen
d. STREET ADDRESS: 419 Baltimore Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First AQUILLA — Middle — Lost FRISBY
4. DATE OF DEATH: Month April — Doy 24 — Year 19 67
5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 22, 1897
9. AGE (In yeors last birthday): 69 yrs.
IF UNDER 1 YEAR: Months — Doys
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custodian (Ret.)
10b. KIND OF BUSINESS OR INDUSTRY: Post Office Dept.
11. BIRTHPLACE (County & State, or foreign country): Harford County, Md.
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: George Frisby (D)
14. MOTHER'S MAIDEN NAME: Harriett Green
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW-I
16. SOCIAL SECURITY NO.: 219-05-0930
17. INFORMANT — Address: Hazel Frisby, Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH
4201
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO (b): ASHD — YEARS
DUE TO (c): ASCVD — YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify thot (I) (this hospital) attended the deceased from DEC. 19 66 to APRIL 19 67, thot (I) (we) last saw the deceased olive on 4/14 19 67, and thot death occurred at 8:40 A.M. from couses ond on the date stoted above.

22a. SIGNATURE: Santiago Leyte-Vidal — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/25/67
22c. PHYSICIAN'S NAME (Type): Santiago Leyte-Vidal M.D.
22d. ADDRESS: 114 W. Bel Air, Aberdeen, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 27 April 67
23c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cemetery
23d. LOCATION (City or Town) (County) (State): Aberdeen, Maryland
24. FUNERAL DIRECTOR: Walter MacCoubrey Sr. — ADDRESS: Tarring Funeral Home, Aberdeen, Md.
25a. REC'D BY REGISTRAR — DATE: APR 27 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05202

CERTIFICATE OF DEATH

05200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Harford — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
   c. LENGTH OF STAY IN 1b: 17hrs.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission)
   a. STATE: Md
   b. COUNTY: Cecil
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   d. STREET ADDRESS: R.D.#3
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mamie — Middle: Ramsey — Last: Gregg

4. DATE OF DEATH: Month: 4 — Day: 6 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 6, 1882

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Ramsey

14. MOTHER'S MAIDEN NAME: Allie Ewing

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Wilhetta Gregg (Son) — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia, of right upper + lower lobes — INTERVAL BETWEEN ONSET AND DEATH: 9 days.
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 490X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized arteriosclerosis + A.S.C.V.D. + C.V.A.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-5, 1967 to 4-6, 1967, that (I) (we) last saw the deceased alive on 4/6 1967, and that death occurred at 6:35 P.M., from causes and on the date stated above.

22a. SIGNATURE: Edward C. Loo, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/6/67

22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.

22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/9/67

23c. NAME OF CEMETERY OR CREMATORY: Moore's Chapel Cemetery, Blake, Cecil Co. Md.

23d. LOCATION (City or Town) (County) (State)

24. FUNERAL DIRECTOR: Ralph E. Hicks — ADDRESS: Hicks Home for Funerals, Elkton, Md.

25a. REC'D BY REGISTRAR DATE: APR 18 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Yeager

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05203

CERTIFICATE OF DEATH

05201

1. **PLACE OF DEATH**
   a. COUNTY: HARFORD — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
   c. LENGTH OF STAY IN 1b: 3 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Md — b. COUNTY: HARFORD
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BEL AIR
   d. STREET ADDRESS: 139 Maulsby Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

12-1

66

3. **NAME OF DECEASED** (Type or print): First: WALTER — Middle: JAMES — Last: HASH, JR.

4. **DATE OF DEATH**: Month: APRIL — Day: 7 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APRIL 4 1967

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days: 3

IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (County & State, or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WALTER JAMES HASH

14. MOTHER'S MAIDEN NAME: MARY EVELYN MCGREEVY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: NONE

17. **INFORMANT** (Father): mr. WALTER JAMES HASH — Address: 139 Maulsby St. Bel Air, Maryland 21014

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cerebral Edema — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): Hemorrhage from Rt. temporal lobe
DUE TO
(c):

760.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from APRIL 4, 1967, to APRIL 7, 1967, that (I) (we) last saw the deceased alive on APRIL 7 1967, and that death occurred at 7:30 AM, from causes and on the date stated above.

22a. SIGNATURE: J. Hash M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/7/67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 8, 1967

23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens

23d. LOCATION (City or Town) (County) (State): Bel Air, Harford Co., Maryland

24. FUNERAL DIRECTOR: Joseph William Foster — ADDRESS: W. Broadway & Williams St. Bel Air, Maryland 21014

25. ACCEPTED BY REGISTRAR — DATE: APR 11 1967

26. REGISTRAR'S SIGNATURE: J. Charles Judge

2-21589

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05204 — 05202

Citizens Nursing Home

1. PLACE OF DEATH — a. COUNTY: HARFORD COUNTY — MARYLAND
Havre de Grace
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Market & Rev. St Havre de Grace
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Citizens Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville, Md 079
d. STREET ADDRESS: Reservoir Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lillie — Middle: — Last: Hornberger
4. DATE OF DEATH: Month: 4 — Day: 26 — Year: 1967
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 5/15/73
9. AGE (In years last birthday): 93 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY: ----------
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry M. Patterson
14. MOTHER'S MAIDEN NAME: Mary Smeltzer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.
16. SOCIAL SECURITY NO. (If yes give wor or dates of service): ----------
17. INFORMANT: 6-2400 T — 20-Paul A. Patterson, Address: Perryville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH: 30 min
DUE TO (b): ASCVD — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
11221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/24/67, 19__, to 4/26/67, 19__, that (I) (we) last saw the deceased alive on 4/26/67 19__, and that death occurred at 11:03 p M, from causes and on the date stated above.

22a. SIGNATURE: A.W. Grigoleit M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/26/67
22c. PHYSICIAN'S NAME (Type): A.W. GRIGOLEIT M.D.
22d. ADDRESS: HAVRE de GRACE

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: April 30, 1967
23c. NAME OF CEMETERY OR CREMATORY: Patterson Fam. Burial Gds.
23d. LOCATION (City or Town) (County) (State): Perryville, Md. Cecil

24. FUNERAL DIRECTOR — ADDRESS: Lee C. Patterson & Son, Perryville, Md.
25a. REC'D BY REGISTRAR — DATE: MAY 3 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)
25M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05205

CERTIFICATE OF DEATH

05203

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Harford — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen Proving Ground
   c. LENGTH OF STAY IN 1b: 3 Days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kirk Army Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Baltimore
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa
   d. STREET ADDRESS: 1001 Old Joppa Road
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: William — Middle: H. B. — Last: HOWARD

4. DATE OF DEATH: Month: April — Day: 9 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 18 February 1904

9. AGE (In years last birthday): 63 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier

10b. KIND OF BUSINESS OR INDUSTRY: Army

11. BIRTHPLACE (County & State, or foreign country): Baltimore County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Benjamin C. Howard

14. MOTHER'S MAIDEN NAME: Katherine Browne

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
    (If yes give war or dates of service): 1942 - 1959

16. SOCIAL SECURITY NO.: 218-10-0348

17. INFORMANT: Wife — Address: (same as above)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Left intracerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (this hospital) attended the deceased from 6 April, 1967, to 9 April, 1967, that (we) last saw the deceased alive on 9 April 1967, and that death occurred at 3:30 PM, from the causes and on the date stated above.

22a. SIGNATURE: Harold C Sheaffer — M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 9 April 1967

22c. PHYSICIAN'S NAME (Type): HAROLD C. SHEAFFER, MAJ, MC

22d. ADDRESS: Kirk Army Hospital, Aberdeen PG, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Apr 12 1967

23c. NAME OF CEMETERY OR CREMATORY: Arlington

23d. LOCATION (City, town or county) (State): Arlington Va

24. FUNERAL DIRECTOR: W.T. Archer — ADDRESS: Benson, Md

25a. REC'D BY REGISTRAR DATE: APR 13 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05206 05204

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address): HARFORD Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Pa
b. COUNTY: Chester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural - Nottingham 75-3
d. STREET ADDRESS: R. D. 2.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Myrtle — Middle: E — Last: Jones

4. DATE OF DEATH: Month: April — Day: 10 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Apr. 22 1891

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): W. Nottingham Twp. Chester Co Pa

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Samuel Grason

14. MOTHER'S MAIDEN NAME: Mary Alice Ferguson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): N

16. SOCIAL SECURITY NO.: 216-05-8933

17. INFORMANT: Lewis F. Jones — Address: Nottingham R.D 2. Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b): Congestive heart failure
DUE TO (c): A.S.C.V.D
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Nat While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-1, 1967 to 4-8, 1967 that (I) (we) last saw the deceased alive on April 10 1967, and that death occurred at 4:15 P M, from couses ond on the date stated above.

22a. SIGNATURE: John D. Yun M.D. — ATTENDING PHYS. ☐ MED DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 4/9/67

22c. PHYSICIAN'S NAME (Type): JOHN D. Yun

22d. ADDRESS: Havre de Grace, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: Apr. 14. 1967

23c. NAME OF CEMETERY OR CREMATORY: Nottingham Cem.

23d. LOCATION (City or Town) (County) (State): Nottingham, Chester Pa

24. FUNERAL DIRECTOR: RALPH M. REED — ADDRESS: RISING SUN, MD.

25a. REC'D BY REGISTRAR DATE: APR 12 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05207

CERTIFICATE OF DEATH

05205

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: D.O.A
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Mass. — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pittsfield
d. STREET ADDRESS: 95 Daniels Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Edward — Middle: E. — Last: Kelleem

4. DATE OF DEATH: Month: April — Day: 29 — Year: 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-12-1906

9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Club Steward

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Penna

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Kelleem

14. MOTHER'S MAIDEN NAME: Tiggie Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Unknown

16. SOCIAL SECURITY NO.: 214-18-3973

17. INFORMANT: Address: Eugenia Kelleem Pittsfield, Mass.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Thrombosis	unkn
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Cardiac Vascular Disease	5 yrs
DUE TO (c)	hypertensive arteriosclerosis	8 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 29, 1967, to April 29, 1967, that (I) (we) last saw the deceased alive on April 29 1967, and that death occurred at 9:45 AM, from the causes and on the date stated above.

22a. SIGNATURE: Edward J. Simon M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): EDWARD J. SIMON

22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-1-67

23c. NAME OF CEMETERY OR CREMATORY: Harmony Chapel

23d. LOCATION (City, town or county) (State): Abingdon, Md.

24. FUNERAL DIRECTOR: Chas. J. Gilson — ADDRESS: Aberdeen, Md.

25a. REC'D BY REGISTRAR — DATE: MAY 3 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05208

CERTIFICATE OF DEATH

05206

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 2 DAYS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
d. STREET ADDRESS: BAYOU VILLA, APT 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: WILLIAM — Middle: SCARFF — Last: Kelly
4. DATE OF DEATH: Month: APRIL — Day: 3 — Year: 1967
5. SEX: MALE
6. COLOR OR RACE: W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JAN. 24, 1887
9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cashier for Arden Dairy, Calif.
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (County & State, or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: EDGAR C. KELLY
14. MOTHER'S MAIDEN NAME: JEANETTE SCARFF
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 520-07-6749
17. INFORMANT: ANNIE W. KELLY — Address: APT. 1A BAYOU VILLA HAVRE DE GRACE, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: x days
DUE TO (b): Arteriosclerotic Cardiovascular Disease — x years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Jan. 5th, 1966, to APRIL 3, 1967, that (I) (we) last saw the deceased alive on APRIL 3, 1967, and that death occurred at 7:35 A.M., from causes and on the date stated above.

22a. SIGNATURE: Edward C. Loo, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/3/67
22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.
22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: APR. 5, 1967
23c. NAME OF CEMETERY OR CREMATORY: ANGEL HILL CEM.
23d. LOCATION (City or Town) (County) (State): HAVRE DE GRACE, MD.

24. FUNERAL DIRECTOR — ADDRESS: R. Madison Mitchell, HAVRE DE GRACE, MD.
25a. REC'D BY REGISTRAR DATE: APR 6 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05203

Reg. Dist. No. 05207

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BEL AIR (RURAL)
c. LENGTH OF STAY IN 1b: 8 MOS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARF. CONVAL. HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCKS (RURAL) 21141
d. STREET ADDRESS: KNOPP Rd 12-1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First MINNIE Middle LUELLA Last KNOPP

4. DATE OF DEATH: Month APRIL Day 1 Year 1967

5. SEX: F

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JANUARY 13, 1880

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOMEMAKER

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HENRY J. HORN

14. MOTHER'S MAIDEN NAME: ANNIE C. OBITS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 220-24-5557

17. INFORMANT: AARON KNOPP Address: OLD FEDERAL HILL ROAD ROCKS, MD 21141

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 1YR
DUE TO (b): ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE — OVER 10 YRS
DUE TO (c): ____

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): DIABETES MELLITUS, PHYSIOLOGIC FRACTURE Rt HIP

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Rt HIP TURNING IN BED DURING NIGHT

20c. TIME OF INJURY Hour NIGHT a. m. p. m. Month, Day, Year FEB 28 1967

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): HOME, HARF. CONVAL.

20f. (City or town) (County) (State): BEL AIR, HARFORD, MD.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Philip W Heuman M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: APRIL 1, 1967

EXAMINER'S NAME (Type): PHILIP W. HEUMAN, M.D. BEL AIR, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 4/4/1967
22c. NAME OF CEMETERY OR CREMATORY: WILLIAM WATTERS
22d. LOCATION (City, town, or county) (State): Cooptown MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: CHARLES E. KURTZ
ADDRESS: JARRETTSVILLE, MD. 21084
24a. REC'D BY REGISTRAR: DATE APR 4 1967
24b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05210 05208

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital - DOA

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood 121
d. STREET ADDRESS 2304 Willoughby Beach Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

99

3. NAME OF DECEASED (Type or print) First BLANCHE Middle LILLIAN Last LANTZ
4. DATE OF DEATH Month APRIL Day 23 Year 1967
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Oct. 6, 1890
9. AGE (In years last birthday) 76 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY home
11. BIRTHPLACE (State or foreign country) Bradshaw, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Leonard Knight
14. MOTHER'S MAIDEN NAME Angeline Ocelia Greenland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 213-36-8900
17. INFORMANT Helen B. Lantz, 2304 Willoughby Beach Road Address Edgewood, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic C V Disease
4321
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Gerald C Palmer M.D.
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED April 24, 1967

2

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF April 26, 1967
23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cemetery
23d. LOCATION (City or Town) (County) (State) Joppa Harford Md

24. FUNERAL DIRECTOR ADDRESS Howard K. McComas & Son, Abingdon, Md. 21009
25a. REC'D BY REGISTRAR DATE APR 26 1967
25b. REGISTRAR'S SIGNATURE Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05211 — Item #1h infor. taken from birth cert. — 05209

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Harford — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
   c. LENGTH OF STAY IN 1b: 36 hr.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Harford
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Churchville, 21028
   d. STREET ADDRESS: Box 94
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby Girl "B" — Middle: — Last: Lawson

4. DATE OF DEATH: Month: April — Day: 27 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-25-67

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: — Days: 1 — IF UNDER 24 HRS.: Hours: 12 — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (County & State, or foreign country): Harford Co. Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Larry Randolph Lawson

14. MOTHER'S MAIDEN NAME: Mary Estella Wisnom

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT (Father): Mr. Larry R. Lawson — Address: Box # 94 Churchville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Insufficiency
DUE TO (b): Respiratory Distress Syndrome
DUE TO (c): Hyaline Membrane Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

7735

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): PREMATURITY

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 25, 1967, to ____, 19____, that (I) (we) last saw the deceased alive on April 27 1967, and that death occurred at 2:47 M, from the causes and on the date stated above.

22a. SIGNATURE: Alonso Gomez — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/27/67

22c. PHYSICIAN'S NAME (Type): ALONSO GOMEZ

22d. ADDRESS: 419 S. Union Ave - Havre de Grace

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 28, 1967

23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens

23d. LOCATION (City, town or county) (State): Bel Air Harford Co. Maryland 21014

24. FUNERAL DIRECTOR: Joseph William Foster — ADDRESS: W. Broadway & Williams St. Bel Air, Maryland 21014

25a. REC'D BY REGISTRAR DATE: MAY 1 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64
7-215082

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05212

CERTIFICATE OF DEATH

05210

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: HARFORD — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
   c. LENGTH OF STAY IN 1b: 3 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Md
   b. COUNTY: HARFORD
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DARLINGTON 121
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: WILLIAM — Middle: WILSON — Last: LEE

4. DATE OF DEATH: Month: APRIL — Day: 15 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: NOV. 7, 1883

9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AUCTIONEER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ADDISON W. LEE

14. MOTHER'S MAIDEN NAME: ELLA P. McCANN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
    (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 218-32-1796

17. INFORMANT: Address: MRS. H.F. ANTHONY, JR., DARLINGTON, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBROVASCULAR ACCIDENT — INTERVAL BETWEEN ONSET AND DEATH: 2 days
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): ARTERIOSCLEROSIS AND CONGESTIVE HT
DUE TO (c): failure

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pneumonitis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/1, 1967, to APRIL 15, 1967, that (I) (we) last saw the deceased alive on APRIL 15 1967, and that death occurred at 12 45 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Dudley Phillips — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/16/67

22c. PHYSICIAN'S NAME (Type): Dudley Phillips

22d. ADDRESS: DARLINGTON, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: APR. 19, 1967

23c. NAME OF CEMETERY OR CREMATORY: DARLINGTON,

23d. LOCATION (City, town or county) (State): DARLINGTON, MD.

24. FUNERAL DIRECTOR — ADDRESS: John H. Harkins, DELTA, PA.

25a. REC'D BY REGISTRAR — DATE: APR 21 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
15M 4-64

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05213

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05211

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen Proving Ground
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kirk Army Hospital DOA

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Ohio — b. COUNTY: Coshocton
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Coshocton 72-3
d. STREET ADDRESS: Route #4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

99

3. NAME OF DECEASED (Type or print): First: Stanley — Middle: — Last: Lewis

4. DATE OF DEATH: Month: April — Day: 15 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 14 June 1915

9. AGE (In years last birthday): 51 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: General Labor

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Lewis

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes give war or dates of service): WW-II

16. SOCIAL SECURITY NO.: 274-12-2158

17. INFORMANT: Dawson Funeral Home, Address: Coshocton, Ohio

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Gerald C. Palmer, M.D.

Address (Street, city, town, or county): Bel Air, Md.

22. DATE SIGNED: 4-15-67

2

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 16 April 67

23c. NAME OF CEMETERY OR CREMATORY: Prairie Chapel Cemetery, Coshocton

23d. LOCATION (City or Town) (County) (State): Ohio

24. FUNERAL DIRECTOR: John D Tarring

ADDRESS: Tarring Funeral Home, Aberdeen, Md.

25a. REC'D BY REGISTRAR DATE: Apr 17 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05214

CERTIFICATE OF DEATH

05212

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen Proving Ground
c. LENGTH OF STAY IN 1b: 4 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kirk Army Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Abingdon 121
d. STREET ADDRESS: 4228 Birch Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles Middle LEONARD Last LINDSEY Jr.

4. DATE OF DEATH: Month April Day 24 Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 21 April 1967

9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR Months Days 4 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Harford, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles L. Lindsey

14. MOTHER'S MAIDEN NAME: ~~Murphy~~ Patricia Murphy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): - (If yes give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Father Address: (Same as above)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity - hyaline membrane pulmonary disease
DUE TO (b): physiologic jaundice
DUE TO (c):

7735

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ~~I~~ (this hospital) attended the deceased from 21 April, 1967, to 24 April, 1967, that ~~I~~ (we) last saw the deceased alive on 24 April 1967, and that death occurred at 540 PM, from the causes and on the date stated above.

22a. SIGNATURE: Leland R. Wight M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 25 April 1967

22c. PHYSICIAN'S NAME (Type): LELAND WIGHT, CPT, MC

22d. ADDRESS: Kirk Army Hospital, APG, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 27, 1967

23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens

23d. LOCATION (City, town or county) (State): Bel Air Harford Co. Maryland 21014

24. FUNERAL DIRECTOR: Joseph William Foster ADDRESS: W. Broadway & Williams St Bel Air, Maryland 21014

25a. REC'D BY REGISTRAR DATE: APR 27 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
15M 4-64

7-270428 Joseph William Foster

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05215

CERTIFICATE OF DEATH

05213

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Harford Memorial

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Perryman~~ Aberdeen, 12.1
d. STREET ADDRESS: Rd 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Emil — Middle: — Last: Macko
4. DATE OF DEATH: Month: 4 — Day: 6 — Year: 1967

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 19 Sept. 1906
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (County & State, or foreign country): Czechoslovakia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Karl Mackovi ~~Unknown~~
14. MOTHER'S MAIDEN NAME: Cecilie Kundraby ~~Unknown~~

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.: 217-14-3768
17. INFORMANT — Address: Alphonse J. Hostinek, Baltimore Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): Coronary arteriosclerosis — 2 years
DUE TO (c): A.S.C.V.D. — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour o.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 20, 1961, to April 6th 1967 that (I) (we) last saw the deceased alive on April 6th 1967, and that death occurred at 2:10 A.M., from causes and on the date stated above.

22a. SIGNATURE: Edward C. Loo, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/6/67
22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.
22d. ADDRESS: Havre de Grace, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8 April 67
23c. NAME OF CEMETERY OR CREMATORY: Spesutia Cemetery
23d. LOCATION (City or Town) (County) (State): Perryman (Harford) Md.

24a. FUNERAL DIRECTOR: Walter Macomber Sr.
ADDRESS: Tarring Funeral Home, Aberdeen, Md.
25a. REC'D BY REGISTRAR — DATE: APR 10 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

4 1

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05216 05214

1. PLACE OF DEATH
   a. COUNTY: Harford — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewood
   c. LENGTH OF STAY IN 1b: 16 years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): --

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Harford
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewood
   d. STREET ADDRESS: 335 McCann Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: VIRGIN — Middle: EDITH — Last: McDANIEL

4. DATE OF DEATH: Month: April — Day: 12 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 16, 1899

9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Kentucky

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William E. Hunter

14. MOTHER'S MAIDEN NAME: Elizabeth Thompson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Address: Mrs. Jewell B. Dudley, 335 McCann St. Edgewood Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Arteriosclerotic C V disease
   DUE TO (b): Diabetes Mellitus
   DUE TO (c):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   260X
   INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐; and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.

EXAMINER'S NAME (Type): Gerald C. Palmer, M.D.

CHIEF MEDICAL EXAMINER ☐ Bel Air, md.
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): Bel Air, Md.

22. DATE SIGNED: 4-13-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 15, 1967

23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens

23d. LOCATION (City or Town) (County) (State): Bel Air Harford Md

24. FUNERAL DIRECTOR ADDRESS: Howard K. McComas & Son, Abingdon, Md.

25a. REC'D BY REGISTRAR DATE: APR 14 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05217

CERTIFICATE OF DEATH

05215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Harford — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Havre de Grace
   c. LENGTH OF STAY IN 1b: 59 Days
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Md
   b. COUNTY: Harford
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa
   d. STREET ADDRESS: 200 Fitshugh Rd
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: ANNA — Middle: Lucille Mc — Last: HENRY

4. DATE OF DEATH: Month: APRIL — Day: 22 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb 28 1899

9. AGE (In years last birthday): 68 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: House Work

11. BIRTHPLACE (County & State, or foreign country): Boyd Co. Ky

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Henry Howell

14. MOTHER'S MAIDEN NAME: Mary Connelly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 261-10-0378

17. INFORMANT: Mrs. Woodyard Bartlett — Address: 200 Fitzhugh Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial infarction, extensive	3 days
DUE TO (b)	Coronary thrombosis	3 days
DUE TO (c)	Arteriosclerotic Cardiovascular Disease	2 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Pyelonephritis, Hypothyroidism, Fatty Degeneration of Liver

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb 23, 1967, to April 22, 1967, that (I) (we) last saw the deceased alive on APRIL 22 1967, and that death occurred at 5 30 A M, from the causes and on the date stated above.

22a. SIGNATURE: Edward C. Loo, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/22/67

22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.

22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 4/26/67

23c. NAME OF CEMETERY OR CREMATORY: Sunset Mem. Park

23d. LOCATION (City, town or county) (State): Pomerton Phila Co. Pa

24. FUNERAL DIRECTOR: Pennypacker Funeral Home — ADDRESS: Havre de Grace Md.

25a. REC'D BY REGISTRAR DATE: APR 25 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Young

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05218 **CERTIFICATE OF DEATH** 05216

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 2 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYland — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
d. STREET ADDRESS: 109 VAN DIVER Ct.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: FRAZier — Last: McMillion

4. DATE OF DEATH: Month: April — Day: 13 — Year: 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11/29/1875
9. AGE (In years last birthday): 91 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: State Road
11. BIRTHPLACE (County & State, or foreign country): Esty, West Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frank McMillion
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): ---
16. SOCIAL SECURITY NO.: 176-07-8734
17. INFORMANT: Mrs. Ann Gregory — Address: 109 Van Diver Ct. Havre de Grace, Md. 21078

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cardio Resp Insufficiency	1 day
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Cerebral arterio sclerosis	1 day
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 12, 1967, to April 13, 1967, that (I) (we) last saw the deceased alive on April 13 1967, and that death occurred at 9:25 A M, from the causes and on the date stated above.

22a. SIGNATURE: Irvin Wachsman M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/13/67
22c. PHYSICIAN'S NAME (Type): Irvin Wachsman
22d. ADDRESS: Havre de Grace, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/15/1967
23c. NAME OF CEMETERY OR CREMATORY: Fallston Methodist
23d. LOCATION (City, town or county) (State): Fallston, Maryland

24. FUNERAL DIRECTOR — ADDRESS: Charles E. Kurtz Jarrettsville, Md. 21084
25a. REC'D BY REGISTRAR DATE: APR 17 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Yingling

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05219 05218

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen
c. LENGTH OF STAY IN 1b D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darlington
d. STREET ADDRESS (Hughes Road) RD 1, Box 80-D
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Charles Middle: William Last: Monk
4. DATE OF DEATH Month: April Day: 22 Year: 19 67

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
M	W	7. MARRIED ☒	DEC. 18, 1939	27 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver
10b. KIND OF BUSINESS OR INDUSTRY Automobile
11. BIRTHPLACE (State or foreign country) Harford Co, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Estell Monk
14. MOTHER'S MAIDEN NAME TENA May Woods

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service) —
16. SOCIAL SECURITY NO. 213-36-9902
17. INFORMANT (Wife) 457-4766 Mrs. Peggy Y. Monk Address RFD #1, Box # 80-D Darlington, Maryland 21034

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fracture of Skull — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto Accident
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 4-22-67
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Conowingo Bridge
20f. (City or town) Rte 1 Darlington (County) Ha (State) Md

21. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Gerald C Palmer M.D.
EXAMINER'S NAME (Type) Gerald C Palmer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county) Bel Air Md.
22. DATE SIGNED 4-23-67

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	April 26, 1967	Bel Air Memorial Gardens	Bel Air, Harford Co, Maryland 21014

24. FUNERAL DIRECTOR Joseph William Foster ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014
25a. RECD BY REGISTRAR DATE APR 25 1967
25b. REGISTRAR'S SIGNATURE Juliana Judge

Joseph William Foster

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05220 05217

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Harford — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
   c. LENGTH OF STAY IN 1b: DOA
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Harford
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace 12-1
   d. STREET ADDRESS: Chapel Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lester — Middle: EARL — Last: Meyers

4. DATE OF DEATH: Month: April — Day: 8 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAR. 19 1902

9. AGE (In years last birthday): 65 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (County & State, or foreign country): PA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wm. G. Meyers

14. MOTHER'S MAIDEN NAME: Laura M. Rogers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): YES NATIONAL GUARD

16. SOCIAL SECURITY NO.: 174-10-2919

17. INFORMANT: Rebecca J. Meyers — Address: RD #2 Box 67 Havre de Grace Md 21078

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden
   DUE TO (b): Arteriosclerotic Cardiovascular Disease — 2-3 years
   DUE TO (c):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb 10th, 1967, to April 8, 1967 that (I) (we) last saw the deceased alive on April 8th 1967, and that death occurred at 2:10 P.M. from causes and on the date stated above.

22a. SIGNATURE: Edward C. Lee M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/8/67

22c. PHYSICIAN'S NAME (Type): Edward C. Lee, M.D.

22d. ADDRESS: Havre de Grace Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 12, 1967

23c. NAME OF CEMETERY OR CREMATORY: HAYS CEM.

23d. LOCATION (City or Town) (County) (State): EASTON North: PA.

24. FUNERAL DIRECTOR: R. Madison Mitchell — ADDRESS: Havre de Grace Md.

25a. REC'D BY REGISTRAR: APR 13 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05221 05219

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Harford
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Fallston
   c. LENGTH OF STAY IN 1b: 39 years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): (U.S. #1) Bel Air Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland b. COUNTY: Harford
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fallston
   d. STREET ADDRESS: (U.S. #1) Bel Air Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Myrtle Middle Florence Last Neikirk

4. DATE OF DEATH: Month April Day 25, Year 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 12, 1889

9. AGE (In years last birthday): 77 yrs.
   IF UNDER 1 YEAR: Months ____ Days ____
   IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Homemaker

11. BIRTHPLACE (County & State, or foreign country): Harford Co., Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob A. Doxen

14. MOTHER'S MAIDEN NAME: Elizabeth Beaumont

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
   (If yes give war or dates of service): ----

16. SOCIAL SECURITY NO.: 213-18-7307

17. INFORMANT (Brother) 838-6148 Address: Mr. William B. Doxen Bel Air, Md. 21014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic CV Disease

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 1-1, 19 15, to 4-25, 1967, that (I) (we) last saw the deceased alive on 4-15 1967, and that death occurred at 9P. M, from the causes and on the date stated above.

22a. SIGNATURE: Gerald C Palmer M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: April 26, 1967

22c. PHYSICIAN'S NAME (Type): Gerald C. Palmer, M.D.

22d. ADDRESS: S. Main St., Bel Air, Md. 21014

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Apr.28,1967

23c. NAME OF CEMETERY OR CREMATORY: Mt. Zion Meth. Ch. Cem.

23d. LOCATION (City, town or county) (State): Fountain Green, Harf.Co., Md.

24. FUNERAL DIRECTOR: Joseph William Foster ADDRESS: W. Broadway & Williams St. Bel Air, Maryland 21014

25a. REC'D BY REGISTRAR DATE: APR 27 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

Joseph William Foster

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05222 05220

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa
c. LENGTH OF STAY IN 1b: 3 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Dragon Wagon Trailer Ct.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa 12.1
d. STREET ADDRESS: 538 Trimble Road Dragon Wagon Trailer Ct
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Walter — Middle: M — Last: Niehoff
4. DATE OF DEATH: Month: April — Day: 22 — Year: 1967
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 6, 1902
9. AGE (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steel Worker
10b. KIND OF BUSINESS OR INDUSTRY: Steel
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Herman Niehoff
14. MOTHER'S MAIDEN NAME: Susan Mercer
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WWII
16. SOCIAL SECURITY NO.: 218-14-5600
17. INFORMANT: Wiley T. Richardson, 1627 Riverwood Rd, Address: Baltimore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic CV Disease — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.
EXAMINER'S NAME (Type): Gerald C Palmer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
Address (Street, city, town, or county): Bel Air, Md
22. DATE SIGNED: 4-22-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: April 24, 1967
23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
23d. LOCATION (City or Town) (County) (State): Bel Air Harford Md
24. FUNERAL DIRECTOR ADDRESS: Howard K. McComas & Son, Abingdon, Md. 21009
25a. REC'D BY REGISTRAR DATE: APR 25 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05223 05221

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Churchville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route #1, Box 466

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Churchville 12.1
d. STREET ADDRESS: Route #1, Box 466
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HAROLD — Middle A. — Last NOBLE JR
4. DATE OF DEATH: Month April — Day 22, — Year 1967

5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 14, 1916
9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Technical Director
10b. KIND OF BUSINESS OR INDUSTRY: U.S.Govt. Aber. Pr. Gd.
11. BIRTHPLACE (County & State, or foreign country): Kansas City, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Dev. & Pr. Svcs. Harold A. Noble Sr.
14. MOTHER'S MAIDEN NAME: Edna Snyder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 511-01-9259
17. INFORMANT — Address: Mrs. Iris Noble, Churchville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Ischemia — INTERVAL BETWEEN ONSET AND DEATH: One hour
DUE TO (b): Myocardial Infarction — One hour
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Atrial fibrillation chronic, Cause Undetermined
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11-17-, 1951, to 4-22-, 1967 that (I) (we) last saw the deceased alive on 4-22-, 1967, and that death occurred at 6:15 PM from causes and on the date stated above.

22a. SIGNATURE: Peter P. Rodman — ATTENDING PHYS. ☒ M.D. — MED. DIRECTOR ☐ — STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Peter P. Rodman, M.D.
22d. ADDRESS: 8 Law Street, Aberdeen, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 26 April 67
23c. NAME OF CEMETERY OR CREMATORY: Harford Memorial Gardens,
23d. LOCATION (City or Town) (County) (State): Aberdeen, Md.

24. FUNERAL DIRECTOR: Webster Macomber Jr.
ADDRESS: Tarring Funeral Home, Aberdeen, Md.

25a. REC'D BY REGISTRAR DATE: APR 26 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05224 05222

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Aberdeen R.F.D.
d. STREET ADDRESS: Stephney Rd. Rt #1 Box 88
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: FRANCES Middle: R. Last: PEEVY

4. DATE OF DEATH: Month: April Day: 25 Year: 1967

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 14 1889
9. AGE (In years last birthday): 77 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (County & State, or foreign country): Berryman Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel Webster
14. MOTHER'S MAIDEN NAME: Mamie Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): —
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 215-28-9016
17. INFORMANT: Mr. John C. Peevy, Aberdeen, Md. Address: Rt #1, Box 88

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Terminal
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Essential Hypertension — 15 yr.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-25-19 67, to 4-25-19 67, that (I) (we) last saw the deceased alive on 4-24-19 67, and that death occurred at 10:00 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Peter P. Rodman M.D.
M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4-25-67
22c. PHYSICIAN'S NAME (Type): Peter P. Rodman M.D.
22d. ADDRESS: Aberdeen Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: April 29, 1967
23c. NAME OF CEMETERY OR CREMATORY: Union Methodist Cem.
23d. LOCATION (City, town or county) (State): Aberdeen, Harford Co. Md.

24. FUNERAL DIRECTOR: Otelia J. Bullock
ADDRESS: 556 Lewis St. Havre de Grace, Md.
25a. RECD BY REGISTRAR: APR 25 1967 DATE
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05225 05223

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 11 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Harford Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 661 Otsego St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Stanley; Middle: ; Last: Ponczek

4. DATE OF DEATH: Month: April; Day: 10; Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/23/1912

9. AGE (In years last birthday): 55 yrs.

IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Steel Works

11. BIRTHPLACE (County & State, or foreign country): Broughton Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Ponczek

14. MOTHER'S MAIDEN NAME: Katherine Pukey (3814 Bryton Place Bronx N.Y. 10469)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): WW 2

16. SOCIAL SECURITY NO.: 232-26-9135

17. INFORMANT (Address): Mrs Stella Neumann

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia.
493X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 9, 1967 to April 10, 1967, that (I) (we) last saw the deceased alive on April 10 1967, and that death occurred at 9:05 M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): 1

23b. DATE THEREOF: 4/15/67

23c. NAME OF CEMETERY OR CREMATORY: Unk

23d. LOCATION (City, town or county) (State): Clarksburg W. Va.

24. FUNERAL DIRECTOR: Cunningham Son, Havre de Grace, Md ADDRESS:

25a. REC'D BY REGISTRAR DATE: APR 13 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 Film #G387 4/17/67 pc

05226

CERTIFICATE OF DEATH

05224

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Penna. — b. COUNTY:
c. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Easton
d. STREET ADDRESS: 1143 Bushkill St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

75.3

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: William — Lost: Potomis
4. DATE OF DEATH: Month: April — Doy: 9 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: DEC. 6, 1896
9. AGE (In yeors lost birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Beth. Steel
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (County & State, or foreign country): Penn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Potomis
14. MOTHER'S MAIDEN NAME: Margaret Getchonis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give wor or dotes of service): World War #1
16. SOCIAL SECURITY NO.: 174-10-8356
17. INFORMANT: Mrs. Sallie R. Potomis — Address: 1143 Bushkill St Easton, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia & Cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH: 3 day
163X
DUE TO
(b): Carcinoma of lung — 1yr
Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this haspital) attended the deceased from 4-7, 1967, to 4-9, 1967 that (I) (we) last saw the deceased alive on 4-9 1967, and that death occurred at 7:35 AM, from causes and on the date stated above.

22a. SIGNATURE: A.W. Grigoleit M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/9/67
22c. PHYSICIAN'S NAME (Type): A.W. GRIGOLEIT
22d. ADDRESS: Havre de Grace

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: APRIL 12, 1967
23c. NAME OF CEMETERY OR CREMATORY: Holy Savior Cem.
23d. LOCATION (City or Town) (County) (State): Bethlehem, North. PA.

24. FUNERAL DIRECTOR — ADDRESS: R. Madison Mitchell, Havre de Grace, Md.
25a. REC'D BY REGISTRAR DATE: APR 13 1967
25b. REGISTRAR'S SIGNATURE: Charles Jagge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires thot the deoth certificote be executed within 24 hours after death. Page 4 moy be retained by the haspital or attending physician.

TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physicion ond completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove corbon papers. Pages 1 ond 2 should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05227

CERTIFICATE OF DEATH

05225

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 23 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Harford Memorial

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fallston
d. STREET ADDRESS: RD 1 Box 87
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Cloud — Last: Pyle

4. DATE OF DEATH: Month: 4 — Day: 4 — Year: 19 67

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: FEB. 13, 1889

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Crown Cork & Seal

10b. KIND OF BUSINESS OR INDUSTRY: RETIRED

11. BIRTHPLACE (County & State, or foreign country): PA. Penna

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Carleton J Pyle

14. MOTHER'S MAIDEN NAME: Elizabeth Mercer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 190-16-9236

17. INFORMANT: Address: DEAN RICHARDS PYLE — FALLSTON, MD. RD #1 BOX 87

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): A.S.C.V.D., Class IV, D. — 2 years.
DUE TO (c): —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Prostatic hypertrophy and urinary retention

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/12, 19 67 to April 4, 1967 that (I) (we) last saw the deceased alive on April 4th 1967 and that death occurred at 6:37 P.M., from causes and on the date stated above.

22a. SIGNATURE: Edward C. Too M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/5/67

22c. PHYSICIAN'S NAME (Type): Edward C. Too, M.D.

22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: APRIL 8, 1967

23c. NAME OF CEMETERY OR CREMATORY: LOUDON PARK CEM.

23d. LOCATION (City or Town) (County) (State): BALTO MD.

24. FUNERAL DIRECTOR: R. Madison Mitchell — ADDRESS: HAVRE DE GRACE, MD

25a. RECD BY REGISTRAR DATE: APR 7 1967

25b. REGISTRAR'S SIGNATURE: Charles Jaeger

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05228

CERTIFICATE OF DEATH

05226

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Cecil Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 07.2
d. STREET ADDRESS: Conowingo, Md
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Boy — Last: Ratliff

4. DATE OF DEATH: Month: 4 — Day: 3 — Year: 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-2-67

9. AGE (In years last birthday) yrs.:

IF UNDER 1 YEAR: Months: . Days: . IF UNDER 24 HRS.: Hours: 16 Min.: 1

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (County & State, or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Marvin Ratliff

14. MOTHER'S MAIDEN NAME: Betty Streed

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Address: Marvin Ratliff - Conowingo Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congenital Heart Disease (Interventricular Septic Defect
DUE TO
(b): Patent Ductus arteriosis
DUE TO
(c):
7543
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/2, 1967, to 4/3, 1967, that (I) (we) last saw the deceased alive on 4/3 1967, and that death occurred at 5:?? M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/3/67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/6/67

23c. NAME OF CEMETERY OR CREMATORY: Stirt

23d. LOCATION (City or town) (County) (State): Rowe Va.

24. FUNERAL DIRECTOR: Jennings Funeral Home

ADDRESS: Havre de Grace, Md

25a. REC'D BY REGISTRAR DATE: APR 10 1967

25b. REGISTRAR'S SIGNATURE: [signature] Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05229

CERTIFICATE OF DEATH

05227

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Harford — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
   c. LENGTH OF STAY IN 1b: 2 yrs.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Convalescing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Harford
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Forest Hill
   d. STREET ADDRESS: Jarrettsville Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Roberta — Middle: R. — Last: Reynolds

4. DATE OF DEATH: Month: April — Day: 11 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4/10/1868

9. AGE (In years last birthday): 99 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Stafford, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Emmor Rees

14. MOTHER'S MAIDEN NAME: Priscilla Ross

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
    (If yes give war or dates of service): ----

16. SOCIAL SECURITY NO.: 218-52-2203

17. INFORMANT: Mrs. Priscilla Stansbury — Address: 112 W. University Parkway Balto. Md. 21210

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 10 min.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Gen. Arteriosclerosis — 30 years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 20, 1947, to Apr. 11, 1967, that (I) (we) last saw the deceased alive on Apr. Mar. 30 1967, and that death occurred at 1 A M, from the causes and on the date stated above.

22a. SIGNATURE: Robert Barthel M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Apr. 11/67

22c. PHYSICIAN'S NAME (Type): Robert Barthel M.D.

22d. ADDRESS: Forest Hill, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/13/1967

23c. NAME OF CEMETERY OR CREMATORY: William Watters

23d. LOCATION (City, town or county) (State): Cooptown, Maryland

24. FUNERAL DIRECTOR: Charles E. Kurtz — ADDRESS: Jarrettsville, Md. 21084

25a. REC'D BY REGISTRAR — DATE: APR 13 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05230

CERTIFICATE OF DEATH

05228

1. PLACE OF DEATH
a. COUNTY: Hafford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen (Rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Route #3,

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen (Rural)
d. STREET ADDRESS: Route #3, Box 69
e. IS RESIDENCE ON A FARM? YES XX NO ☐

3. NAME OF DECEASED (Type or print): First ALICE Middle W. Lost RICHARDSON

4. DATE OF DEATH: Month April Doy 4, Year 19 67

5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 26 July 1893
9. AGE (In years lost birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Harford County, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George E. Wright
14. MOTHER'S MAIDEN NAME: Emma Elizabeth James

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.: 220-46-1087
17. INFORMANT Address: G. Willard Richardson, Aberdeen, Md,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure
DUE TO (b): Arteriosclerotic vascular and
Conditions, if ony, which gave rise to immediate couse (a), stating the underlying couse lost. DUE TO (c): heart disease
INTERVAL BETWEEN ONSET AND DEATH: over yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____, 19__, to ____, 19__; that (I) (we) last saw the deceased alive on ____, 19__; and that death occurred at 9:30 PM, from causes and on the date stoted above.

22a. SIGNATURE: L. Mezei M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/5/67.
22c. PHYSICIAN'S NAME (Type): L. Mezei, M.D.
22d. ADDRESS: Havre de Grace, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7 April 67
23c. NAME OF CEMETERY OR CREMATORY: Spesutia Cemetery
23d. LOCATION (City or Town) (County) (Stote): Perryman (Harford) Md.

24. FUNERAL DIRECTOR: Webster MacCombie Sr.
ADDRESS: Tarring Funeral Home, Aberdeen, Md.
25a. REC'D BY REGISTRAR DATE: APR 7 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05231 **CERTIFICATE OF DEATH** 05229

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Benson
d. STREET ADDRESS: 703 Whitaker Mill Rd.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First John — Middle F. — Last Shanahan

4. DATE OF DEATH: Month April — Day 29 — Year 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 4 1905

9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Care Taker C.F.A.C.

10b. KIND OF BUSINESS OR INDUSTRY: Manager

11. BIRTHPLACE (County & State, or foreign country): md. Balto.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Shanahan

14. MOTHER'S MAIDEN NAME: Louise Kearney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 215-01-2332

17. INFORMANT: Kathryn L. Shanahan — Address: 703 Whitaker Mill Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma head of Pancreas with — INTERVAL BETWEEN ONSET AND DEATH

157X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Jaundice obstruction and massive
DUE TO (c): bilateral adrenal metastases

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2Df. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/27, 1967, to April 29 1967 that (I) (we) last saw the deceased alive on April 29, 1967, and that death occurred at 10:45 A M, from the causes and on the date stated above.

22a. SIGNATURE: Edward C. Loo, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/29/67

22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.

22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 2-67

23c. NAME OF CEMETERY OR CREMATORY: St. John's Cem.

23d. LOCATION (City, town or county) (State): Long Green Md.

24. FUNERAL DIRECTOR: Riggs Bros. Inc. — ADDRESS: 7110 Belair Rd. Balto.

25a. REC'D BY REGISTRAR DATE: MAY 3 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05232

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05230

1. **PLACE OF DEATH**
   a. COUNTY: Harford — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital - DOA

2. **USUAL RESIDENCE** (Where deceased lived, if institutian: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Harford
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewood
   d. STREET ADDRESS: 3917 Love Drive
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: FRED — Middle: LEONARD — Last: SHEETS

4. **DATE OF DEATH**: Month: APRIL — Day: 26 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 23, 1929

9. AGE (In years last birthday): 37 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind af wark done during mast af working life, even if retired): Mechanic

10b. KIND OF BUSINESS OR INDUSTRY: auto

11. BIRTHPLACE (State ar foreign country): Bakersville, N.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Isaac Sheets

14. MOTHER'S MAIDEN NAME: Rose Fyre

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknown): no — (If yes give war ar dates af service)

16. SOCIAL SECURITY NO.: 409-460428

17. **INFORMANT**: Address: Balto., Md. — Mrs. Evelyn Sheets, 5 W.Midland Ave.,

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only ane cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fracture Skull — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditians, if any, which gave rise ta immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ ar CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II af item 18.): Auto Accident

20c. TIME OF INJURY Hour: 4 50 a.m. p.m. — Month, Day, Year: 4-26 19 67

20d. INJURY OCCURRED While at work ☐ Not While at wark ☐

20e. PLACE OF INJURY (Hame, farm, factary, street, office bldg., etc.): Willoughby Beach Rd

20f. (City or town): Edgewood (County): Ha (State): Md.

21. **I certify** thot I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ and in my opinian death resulted from: Natural causes ☐, Accident ☒ Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.

CHIEF MEDICAL EXAMINER ☐ Bel Air, Md.
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Gerald C Palmer- MD

Address (Street, city, town, or county):

22. DATE SIGNED: 4-26-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: Apr 26, 1967

23c. NAME OF CEMETERY OR CREMATORY: Henline Funeral Home

23d. LOCATION (City ar Town): Bakersville (County): Mitchell Co., (State): N. C

24. FUNERAL DIRECTOR — ADDRESS: Howard K. McComas & Son, Abingdon, Md. 21009

25a. REC'D BY REGISTRAR — DATE: MAY 1 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05233

CERTIFICATE OF DEATH

05231

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
c. LENGTH OF STAY IN 1b: 23 days.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East
d. STREET ADDRESS: Rd #1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Lyman — Middle: Jones — Last: Smith.

4. DATE OF DEATH: Month: 4 — Day: 22 — Year: 1967.

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 20, 1881

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward B Smith

14. MOTHER'S MAIDEN NAME: Hanna Gunthrie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 215-36-8014

17. INFORMANT: Minnie C. Smith — Address: R.D.#1 North East, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypostatic pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Cardiovas-
DUE TO (c): cular Disease — ?

4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-1, 1967 to 4-22, 1967 that (I) (we) last saw the deceased alive on 4/22/1967, and that death occurred at 7:33 PM, from the causes and on the date stated above.

22a. SIGNATURE: Edward C. Loos M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 4/22/67

22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D. — 22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 4/26/67 — 23c. NAME OF CEMETERY OR CREMATORY: Bay View Meth — 23d. LOCATION (City, town or county) (State): Cecil Co. Md.

24. FUNERAL DIRECTOR: Grant Funeral Home — Paul R. Crouch — ADDRESS: Box 22 North East, Md

25a. RECD BY REGISTRAR DATE: APR 26 1967 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 8 & 9 Film C388 5/11/67 kk

05234

CERTIFICATE OF DEATH

05232

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md — b. COUNTY: Harford

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 1 day
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Abingdon 12.1

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Harford Memorial
d. STREET ADDRESS: 4117 Baker Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mary — Middle: A. — Lost: Steptoe
4. DATE OF DEATH: Month: 4 — Day: 8 — Year: 1967

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 6/10/1881 85
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work.
10b. KIND OF BUSINESS OR INDUSTRY: Home work.
11. BIRTHPLACE (County & State, or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Long
14. MOTHER'S MAIDEN NAME: Rebecca Ellwood.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: Winifred S. Powd. Wil. Delaware

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): A.S.C.V.D. — 5-6 Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last. DUE TO (c):
4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senility
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April 7, 1967 to Admitted, 1967 that (I) (we) last saw the deceased alive on April 8 1967, and that death occurred at 6A M, from causes and on the date stated above.

22a. SIGNATURE: Edgar C. Moore M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/8/67
22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.
22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF: 4/11/67
23c. NAME OF CEMETERY OR CREMATORY: Silverbrook.
23d. LOCATION (City or Town) (County) (State): Wilmington. New Castle. Del.

24. FUNERAL DIRECTOR — ADDRESS: Peppin Funeral Home. Elkton Maryland
25a. REC'D BY REGISTRAR DATE: APR 11 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05235 05233

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Darlington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Susquehanna River

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Airy
d. STREET ADDRESS: 109 Prospect Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: Francis — Last: Thomas, Jr.

4. DATE OF DEATH: Month: April — Day: 14 — Year: 19 67

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 10, 1942

9. AGE (In years last birthday): 24 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert F. Thomas, Sr.

14. MOTHER'S MAIDEN NAME: Edith Haines

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give wor or dates of service)

16. SOCIAL SECURITY NO.: 218-40-0863

17. INFORMANT: Martha L. Thomas, — Address: Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia due to Drowning
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
850X

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.): Fell out of Boat

20c. TIME OF INJURY Month, Day, Year: Hour o.m. p.m. 3-31 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Susquehanna R.

20f. (City or town) (County) (State): Darlington Md

21. I certify thot I took chorge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinian death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE OF EXAMINER: Gerald E Palmer M.D.
EXAMINER'S NAME (Type): Gerald E Palmer MD
CHIEF MEDICAL EXAMINER ☐ Bel Air, Md
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
22. DATE SIGNED: 4-14-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/16/67
23c. NAME OF CEMETERY OR CREMATORY: Pine Grove
23d. LOCATION (City or Town) (County) (State): Mt. Airy, Md.

24. FUNERAL DIRECTOR — ADDRESS: Olin L. Molesworth, Damascus, Md.

25a. REC'D BY REGISTRAR — DATE: APR 17 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05236

CERTIFICATE OF DEATH

05234

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
20M S-63

1. **PLACE OF DEATH**
   a. COUNTY: Harford — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
   c. LENGTH OF STAY IN 1b: Unk.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Citizens Nursing Home

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Harford
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
   d. STREET ADDRESS: 6I4 Shamrock Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Charles — Middle: Sthaley — Last: Thorn

4. **DATE OF DEATH**: Month: April — Day: I7, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug 23, I886

9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months 4 Days I7 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (County & State, or foreign country): Bordentown , N.J.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David C. Thorn

14. MOTHER'S MAIDEN NAME: Ida Z. Elliott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: Unknown

17. **INFORMANT** Address: Mr. Charles S. Thorn Jr. Bel Air, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 2 months

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Adenocarcinoma of Colon — 6 months

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from March 14th 1967 to April 17th 1967 that (I) (we) last saw the deceased alive on April 17th 1967, and that death occurred at 1:00 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Edward C. Loo, M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/17/67

22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.

22d. ADDRESS: 211 N. Union Ave. Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: April 20, I967

23c. NAME OF CEMETERY OR CREMATORY: Bordentown Cemetery

23d. LOCATION (City, town or county) (State): Bordentown, New Jersey

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Pennington & Son Havre de Grace Md

25a. REC'D BY REGISTRAR DATE: APR 20 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05237 — 05235

FOR STATE HEALTH DEPT. M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: Route #1, Box 247
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Edward		Turnbaugh	April	6	1967

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
M	W	MARRIED [X]	11 Feb. 1891	76 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Farm	Baltimore County Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Turnbaugh	Mary Ann Cockran

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. (If yes give wor or dates of service)	17. INFORMANT Address
No	217-07-6644-A	Clarence D. Turnbaugh, Churchville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Injuries — DUE TO
9123
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) — DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Tractor rolled on him

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work [ ] Not While at work [X]	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
11:35 a.m. 4-6-1967		Service Sta.	Havre de Grace	Harford	Md

21. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Gerald C Palmer, M.D.
EXAMINER'S NAME (Type): Gerald C Palmer M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county): Bel Air, Md.
22. DATE SIGNED: 4-6-67

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	9 April 67	Jarrettsville Cemetery	Jarrettsville,	Md.	

24. FUNERAL DIRECTOR: Tarring Funeral Home, Aberdeen, Md.
DATE RECD BY REGISTRAR: APR 10 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5)
6M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05238

CERTIFICATE OF DEATH

05236

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air 1211
d. STREET ADDRESS: 317 Wakefield Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: John — Middle: Henry — Last: Unglaub.

4. DATE OF DEATH: Month: 4 — Day: 29 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 27, 1874

9. AGE (In years last birthday): 93 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman

10b. KIND OF BUSINESS OR INDUSTRY: Penn. R.R.

11. BIRTHPLACE (County & State, or foreign country): Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Miller Unglaub.

14. MOTHER'S MAIDEN NAME: Wilhelmina Haug.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 217-07-6971

17. INFORMANT — Address: Doris J. Stemler, dght. above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 month
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 150X
(b): Transitional Ca of left kidney & bilateral — unknown
DUE TO
(c): acut & chronic pyelonephritis & hemorrhage

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-24, 1967, to 4-29, 1967, that (I) (we) last saw the deceased alive on 4/29/67 19___, and that death occurred at 4:P M, from couses and an the date stated above.

22a. SIGNATURE: Chas Grigoleit MD
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/29/67
22c. PHYSICIAN'S NAME (Type): A.W. GRIGOLEIT
22d. ADDRESS: HAVRE de GRACE

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/2/67
23c. NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery
23d. LOCATION (City or Town) (County) (State): Baltimoe, Md.

24. FUNERAL DIRECTOR: Schimunek Funeral Home — ADDRESS: 3331 Brehms Lane #13

25a. REC'D BY REGISTRAR: DMAY 2 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 hours after deoth. Poge 4 moy be retained by the hospital or attending physicion.

TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremotion, or removol, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05239 05237

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 666 Green St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry — Middle: — — Last: Vantor

4. DATE OF DEATH: Month: April — Day: 9 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 2/10/1892
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Restaurant Owner
11. BIRTHPLACE (County & State, or foreign country): Greece
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nicholas Vantor
14. MOTHER'S MAIDEN NAME: Kathleen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: unk.
17. INFORMANT: Kathleen Vantor — Address: 666 Green St. apt. 3 Havre de Grace Md. 21078

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Standstill — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO (b): Chronic Cardiac Decompensation — ?
DUE TO (c): A.S.C.V.D. — > 2 to 3 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4330

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus, bilateral pleural effusion

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/31st, 1967, to 4/9th 1967, that (I) (we) last saw the deceased alive on 4/9th 1967, and that death occurred at 6:18 AM, from causes and on the date stated above.

22a. SIGNATURE: Edward C. Loo, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/9/1967
22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.
22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/12/67
23c. NAME OF CEMETERY OR CREMATORY: Angel Hill
23d. LOCATION (City or Town) (County) (State): Havre de Grace Md.

24. FUNERAL DIRECTOR: Pennington Sons — ADDRESS: Havre de Grace, Md.
25a. REC'D BY REGISTRAR: APR 12 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05240 05238

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: HARFORD
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 2 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: Rt 1; Box 107
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Fred; Middle: ; Last: Veeder
4. DATE OF DEATH: Month: APRIL; Day: 22; Year: 1967
5. SEX: MALE
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 29, 1889
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter (Ret.)
10b. KIND OF BUSINESS OR INDUSTRY: Const.& Bldg.
11. BIRTHPLACE (County & State, or foreign country): ~~XXXX~~ New York
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 218-07-8168
17. INFORMANT: Frances E. Veeder, Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ruptured aortic aneurysm — INTERVAL BETWEEN ONSET AND DEATH: 1 hr
DUE TO (b): Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
OUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a.m. p.m.; 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 22, 1967, to April 22, 1967, that (I) (we) last saw the deceased alive on APRIL 22 1967, and that death occurred at 4:45 A M, from the causes and on the date stated above.

22a. SIGNATURE: Richard J. Colfer M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 4/22/67
22c. PHYSICIAN'S NAME (Type): Richard J. Colfer, M.D.
22d. ADDRESS: Havre de Grace, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 25 April 67
23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
23d. LOCATION (City, town or county) (State): Bel Air, Maryland

24. FUNERAL DIRECTOR: John G. Tarring
ADDRESS: Tarring Funeral Home, Aberdeen, Md.
25a. REC'D BY REGISTRAR DATE: APR 25 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05241 05239

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): Joppa
c. LENGTH OF STAY IN 1b: 25 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): --

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): Joppa
d. STREET ADDRESS: 2302 Mountain Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Lost	4. DATE OF DEATH Month	Doy	Year
LOUIS	MILTON	WAGONER	April	17	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In yeors last birthdoy)	IF UNDER 1 YEAR Months / Doys	IF UNDER 24 HRS. Hours / Min.
Male	White	NEVER MARRIED ☒	Sept. 12, 1918	48 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & Stote, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck Driver	Transfer	Harford County, Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Mahlon C. Wagoner, Sr.	Zollie M. Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no	219-07-9749	Mahlon C. Wagoner, Jr., 2302 Mountain Road, Joppa, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): For Advanced Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 9 yrs
DUE TO (b):
Conditions, if any, which gove rise to immediote couse (o), stoting the underlying couse last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)				
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19	20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(Stote)

21. **I certify** that (I) (this haspital) attended the deceased from 6-1, 1966, to 4-17, 1967, that (I) (we) last saw the deceased alive an 4-17 1967, and that death occurred at 4 p M, from causes and an the date stated abave.

22a. SIGNATURE: Fred O. Hodous — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 4-18-67
22c. PHYSICIAN'S NAME (Type): Fred O. Hodous, M.D. — 22d. ADDRESS: Edgewood, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(Stote)
Burial	April 20, 1967	Oak Grove Cemetery	Bel Air R.D.	Harford	Md

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Howard K. McComas & Son, Abingdon, Md.	APR 20 1967	J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be farwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05242

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05240

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DeA Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: Hendricks Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: E — Last: Walker

4. DATE OF DEATH: Month: April — Day: 21 — Year: 19 67

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Sept. 28-1930

9. AGE (In years last birthday): 36 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): A.C. Linemd

10b. KIND OF BUSINESS OR INDUSTRY: Government

11. BIRTHPLACE (State or foreign country): W. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert C. Walker

14. MOTHER'S MAIDEN NAME: Virginia Burton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): Jordan

16. SOCIAL SECURITY NO.: unk.

17. INFORMANT — Address: Chapman Funeral Home, Huntington W Va

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Exsanguination due to laceration
DUE TO
(b): Neck vessels
DUE TO
(c):
Conditions, if ony, which gove rise to immediote couse (o), stating the underlying couse lost.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.): Auto Accident

20c. TIME OF INJURY Month, Day, Yeor Hour o.m.: 2:30 p.m. 4-21 19 67

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my apinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.

EXAMINER'S NAME (Type): Gerald C Palmer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐ Bel Air Md.
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: 4-21-67

Address (Street, city, town, or county):

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/24/67

23c. NAME OF CEMETERY OR CREMATORY: ?

23d. LOCATION (City or Town) (County) (State): Huntington W. Va

24. FUNERAL DIRECTOR — ADDRESS: Cunningham & Son, Havre de Grace, Md

25a. REC'D BY REGISTRAR — DATE: APR 25 1967

25b. REGISTRAR'S SIGNATURE: J Charles Young

VR A15ME (5)
6M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05243 — Items 1 & 23c & 23d Film G308 2/1/67 KK — 05241

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
   a. COUNTY: HARFORD — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): —
   c. LENGTH OF STAY IN 1b: —
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD COUNTY JAIL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: New Jersey — b. COUNTY: —
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bridgeton 673
   d. STREET ADDRESS: 70 Vine Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: EVERETT — Middle: R. — Last: WALLS

4. DATE OF DEATH: Month: April — Day: 17, — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Unknown

9. AGE (In years last birthday): 41 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ?

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Caril-Padgett Funeral Home — Address: 208 E. Commerce St. Bridgeton, N.J.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia by hanging — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): (Partial)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Hanged self in jail

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m.: 4-17 19 67

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): jail (Partial)

20f. (City or town) (County) (State): HARFORD, MD.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county): —

22. DATE SIGNED: April 17, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 4/18/67

23c. NAME OF CEMETERY OR CREMATORY: Center Grove Meth.

23d. LOCATION (City or Town) (County) (State): Cumberland, N. J.

24. FUNERAL DIRECTOR — ADDRESS: Wm. Cook-Brooks Inc. Baltimore, Md. 21202

25a. REC'D BY REGISTRAR DATE: APR 24 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05244 05242

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 20 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Harford Mem. Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 612 Bourbon St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First (Mrs.) Beulah Middle Elizabeth Last Walter

4. DATE OF DEATH: Month April Day 28 Year 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 27-1895

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): Harford Co. Md

12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: Walter M. Smith

14. MOTHER'S MAIDEN NAME: Sarah McCall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: unk.

17. INFORMANT: Edmund Walter — Address: 612 Bourbon St. Havre de Grace, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ventricular fibrillation — INTERVAL BETWEEN ONSET AND DEATH: Sudden
416 X
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Old rheumatic and arteriosclerotic
DUE TO (c): Cardiovascular Disease — 6 Months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Saddle Shaped thrombosis of abdominal + iliac aorta

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/8, 1967, to 4/28, 1967, that (I) (we) last saw the deceased alive on 4/28 1967, and that death occurred at 12:30 M, from the causes and on the date stated above.

22a. SIGNATURE: Edward Coddington, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/28/67

22c. PHYSICIAN'S NAME (Type): Edward C. Coddington, M.D.

22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): B

23b. DATE THEREOF: 5/2/67

23c. NAME OF CEMETERY OR CREMATORY: Angel Hill

23d. LOCATION (City, town or county) (State): Havre de Grace Md

24. FUNERAL DIRECTOR: Pennington & Son — ADDRESS: Havre de Grace Md

25a. REC'D BY REGISTRAR — DATE: MAY 3 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05245

CERTIFICATE OF DEATH

05243

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): ABERDEEN
c. LENGTH OF STAY IN 1b: 15 YRS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 126 CARROLL AVE

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MD — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ABERDEEN
d. STREET ADDRESS: 126 CARROLL AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LOTTIE — Middle MARROW — Last WORTHINGTON

4. DATE OF DEATH: Month APRIL — Day 29 — Year 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JUNE 13, 1883

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: RETIRED

11. BIRTHPLACE (County & State, or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLE C. BOWMAN

14. MOTHER'S MAIDEN NAME: LUCY GORRELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): ___ (If yes give war or dates of service): ___

16. SOCIAL SECURITY NO.: 218-10-3376-D

17. INFORMANT: Mrs. Lucy Virginia McPHAIL — Address: ABERDEEN, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Azotemia	5 days
446X DUE TO (b)	Anuria	5 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Nephrosclerosis	3 mo

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour ___ a.m. p.m. — Month, Day, Year: 19___

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-18-1950 19___, to 4-29-1967, that (I) (we) last saw the deceased alive on 4-28-1967, and that death occurred at 2:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-1-67

22c. PHYSICIAN'S NAME (Type): Peter P. Rotman, M.D.

22d. ADDRESS: 8 Law St., Aberdeen, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: MAY 2, 1967

23c. NAME OF CEMETERY OR CREMATORY: ANGEL HILL CEM.

23d. LOCATION (City, town or county): HAVRE DE GRACE (State): MD

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: R. Madison Mitchell, Havre de Grace, Md.

25a. REC'D BY REGISTRAR: DATE MAY 2 1967

25b. REGISTRAR'S SIGNATURE: [signature] Charles Judge

VR A1S (4)
20M S-63